Narrative Exposure Improves PTSD Symptoms

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CHICAGO — Short-term narrative exposure therapy can be effective in treating posttraumatic stress disorder in child and adult survivors of war, even when carried out by lay counselors with limited training, new research shows.

Narrative exposure therapy (NET) builds on the tradition of testimony therapy in which patients are asked to repeatedly talk about a traumatic event in detail and reexperience all emotions associated with the event. This leads to habituation of the emotional response to the traumatic memory and a subsequent lessening of PTSD symptoms.

Researchers at the University of Konstanz (Germany), led by Frank Neuner, Ph.D., adapted this approach for use in victims of war and organized violence because it can be difficult for these patients to identify a single worst event, and multiple traumatic events can distort autobiographic memory.

In NET, patients are asked to construct a narrative of their entire life from birth to the present, while focusing on all traumatic experiences. Because language is the main tool of narrative therapy, NET was further adapted for use in children (KIDNET) to include the use of illustrative media such as drawing or reenactment using body positioning.

The latest studies to evaluate NET and KIDNET were presented by Dr. Neuner and his associates at the annual meeting of the International Society for the Study of Traumatic Studies.

One study randomized 26 refugee children living in Germany to eight 90- to 120-minute sessions of KIDNET conducted over 2 months or a waiting list control group. Their mean age was 11 years, and they had suffered an average of four traumatic events.

The average symptom score on the University of California, Los Angeles, PTSD Index was reduced from 43.3 at baseline to 17.2 at 6 months in the KIDNET group, compared with only a small reduction from 38.3 to 33.8 in the waiting list group, reported Martina Ruf, Ph.D., of the University of Konstanz. The effect size was a robust 1.9 with KIDNET.

One study involved 87 former child soldiers who had been abducted into the Lord's Resistance Army, a guerilla army operating in Uganda that is notorious for its cruelty.

Reductions also were seen with KIDNET in symptoms of intrusion (effect size 2.3), avoidance (2.1), and hyperarousal (1.0). The effect of KIDNET was seen at 4 weeks and continued through 12 months of follow-up, she said.

The children had been in exile for a mean of 31 months from a variety of countries including Turkey, Chechnya, Georgia, and Russia. The use of a translator did not alter the effectiveness of KIDNET, Dr. Ruf said.

A second randomized, controlled study evaluated the use of community-based NET among 87 former child soldiers, aged 12-25 years (mean, 18 years), who had been abducted into the Lord's Resistance Army, a guerilla army operating in Uganda that is notorious for its cruelty and use of skinning, maiming, rape, and murder. The average abduction lasted roughly 5 months, and typically occurred 7 years earlier, at age 11.

Patients were randomized to three groups: eight sessions of NET carried out by local counselors trained in both theory and practice; an active control group given supportive counseling, psychoeducation, and English language lessons; or a waiting list control group. Preliminary data were available on 57 patients who had finished treatment.

At 3 months post therapy, Clinician-Administered PTSD Scale (CAPS) sum scores decreased in all three groups, likely because the study was started during a brief period of peace in which child abductions were halted, reported Verena Ertl, a Ph.D., candidate also at the University of Konstanz.

At 12 months after therapy, however, there was a significant reduction from baseline in CAPS sum scores with NET (mean 66.16 to 34.11), compared with active control (60.84 to 46.68), and control (64.0 to 48.42).

NET also proved superior to active control in reducing reports of spirit possession and discrimination against formerly abducted children, but had no impact on self-reported aggression.

Taken together, the findings show that NET can be an effective treatment, even in highly affected groups like child soldiers, and when carried out as a community intervention, Ms. Ertl concluded at the meeting, which was sponsored by Boston University. "It's also quite cost-effective," she said.

Similar results were reported by Dr. Neuner on the use of NET administered in a refugee camp by nine refugees with a secondary school level education and 6 weeks of training, including direct observation.

At 9 months follow-up, adult Rwandese and Somali refugees with PTSD randomized to strictly manualized NET (n = 111) or more flexible trauma counseling (n = 111) were statistically and clinically superior in terms of PTSD symptoms and physical health, compared with 55 refugees randomized to a no-treatment monitoring group. CAPS sum scores improved from baseline with both NET (25.9 to 6.1) and trauma counseling (26.7 to 5.0).

However, 20% of the trauma counseling group dropped out of treatment, whereas only 4% of the NET group did, said Dr. Neuner, who is now with the University of Bielefeld, Germany.

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Depot Nears Approval

Olanzapine *from page 1*

At the annual psychiatric institute, Dr. Detke and her colleagues presented several major studies of olanzapine LAI, including a large, 24-week, randomized, double-blind efficacy trial; an analysis of treatment-related metabolic changes; and an update on the complication known as postinjection delirium/sedation syndrome.

There were 29 occurrences of postinjection delirium/sedation syndrome (PDSS) in 28 of the more than 2,000 patients involved in olanzapine LAI clinical trials through May 31, 2008. This works out to an incidence of 0.07% per injection, based upon a total of more than 40,000 injections. The cumulative risk per patient after 1 year of treatment was 0.7%-1.2%, depending upon the injection schedule.

The signs and symptoms of PDSS are those of olanzapine overdose. They include sedation, dizziness, confusion, disorientation, slurred speech, muscle spasms, weakness, altered gait, agitation, and extrapyramidal symptoms. There have been two instances of seizure and several episodes involving loss of consciousness but no arrhythmias or clinically meaningful decreases in vital signs.

Most affected patients were hospitalized during their PDSS episode. All recovered completely in 1.5-72.0 hours with routine medical management. Overall, 70% of affected patients continued on olanzapine LAI afterward, underscoring the high value placed on a depot antipsychotic.

Olanzapine LAI is given intramuscularly by deep gluteal injection. It's thought that PDSS results from accidental intravascular injection, a potential risk with any intramuscularly administered drug. For example, the incidence of PDSS with olanzapine LAI is quite similar to the 0.08% rate of systemic toxic reactions per injection reported for intramuscular procaine penicillin G (Sex. Transm. Dis. 1978;5:4-9), Dr. Detke noted.

She and her coinvestigators proposed several precautions in giving olanzapine LAI, including a postinjection observation period of at least 3 hours in a health care facility, and a warning to patients not to operate a car or other machinery for the rest of the day. Proper injection technique includes aspiration of the syringe for about 5 seconds prior to injection while making sure no blood is visible.

The metabolic parameters study involved 921 adults with schizophrenia who were first stabilized on 10-20 mg/day of oral olanzapine for 4 weeks, then randomized to 24 weeks of continued oral olanzapine or to olanzapine LAI at 150 mg every 2 weeks, 300 mg every 2 weeks, 45 mg every 4 weeks, or 405 mg every 4 weeks.

In general, metabolic changes over the 24-week study period were similar in the groups receiving oral and LAI olanzapine. Roughly 20% of patients in either group showed a 7% or greater gain in body weight. Interestingly, patients who were obese at baseline experienced significant increases in body weight and body mass index only on oral olanzapine. With LAI therapy, obese patients showed a modest weight loss.

Mean fasting blood glucose rose by 3.1 mg/dL in the olanzapine LAI–treated patients overall, although the change from baseline was significant only for the subgroup on 405 mg every 4 weeks. Blood glucose levels rose to a similar degree in patients who received the oral formulation.

Mean LDL cholesterol levels dropped by an average of 6.4 mg/dL in the group on oral olanzapine, by 11.6 mg/dL in those on olanzapine LAI at 45 mg every 4 weeks, by 1.6 mg/dL for those on 150 mg every 2 weeks, and by 2.7 mg/dL for those on 405 mg every 4 weeks. LDL cholesterol increased nonsignificantly by 0.8 mg/dL in patients receiving 300 mg every 2 weeks.

Fasting triglycerides climbed by 11.3 mg/dL with 24 weeks of oral olanzapine, and declined by 4.3 mg/dL with LAI therapy. HDL cholesterol levels were unaffected by treatment.

The maintenance therapy trial involved 1,065 adult schizophrenia patients who were stabilized on open-label oral olanzapine for 4-8 weeks before double-blind randomization to one of the four olanzapine LAI dosing schedules or to continued oral olanzapine. At 24 weeks, the rate of freedom from exacerbation was 93% in the oral treatment arm, 95% with LAI at 300 mg every 2 weeks, 90% with 405 mg every 4 weeks, 84% with 150 mg every 2 weeks, and 69% with 45 mg every 4 weeks.

Of patients on oral olanzapine, 21% experienced a clinically meaningful 7% or greater increase in weight. So did 8% of patients on LAI at 45 mg every 4 weeks, 16% on 150 mg every 2 weeks, 15% on 405 mg every 4 weeks, and 21% on 300 mg every 2 weeks. On average, however, weight changes over the 24 weeks were modest, ranging from a mean 1.0-kg loss in the lowest-dose LAI arm to gains of 0.7-1.7 kg with the other three LAI dosing schedules, and 1.3 kg with oral therapy.

Long-acting injectable risperidone administered every 2 weeks was the first depot atypical antipsychotic to reach the market. Also under FDA review is paliperidone palmitate, an every-4-weeks injectable. Iloperidone is another depot agent that is well along in the developmental pipeline. ■